FINAL REPORT

SECOND ANNUAL

GOVERNOR'S CONFERENCE ON HEALTH EDUCATION

sponsored by

MHA

Montana Health Association

COLONIAL — HELENA

April, 1974

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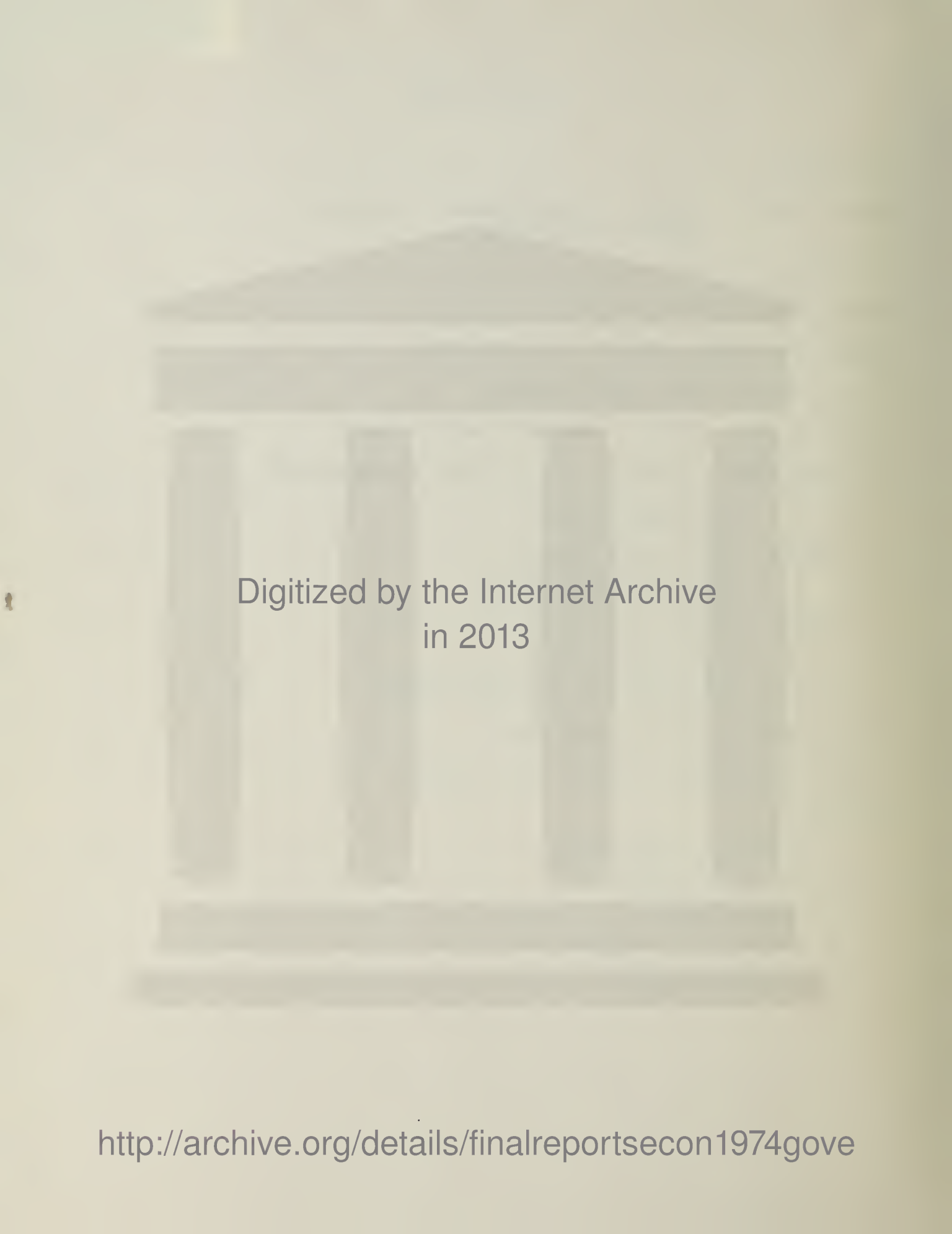

INTRODUCTION

The GOVERNOR'S CONFERENCE ON HEALTH EDUCATION was held in two parts. The first Conference was held in April 1973. The planning committee charged that the first conference should determine the problems in health education relating to the schools and to the community. Discussion topics were explored as to: 1) What is the situation at present? 2) What should it be? and 3) What is needed? The outcome of these discussions is contained in the Summary of the First Governor's Conference in this report on page ten.

The Governor's Conferences on Health Education have been sponsored by the Montana Health Association in cooperation with State Agencies and organizations interested in and responsible for school and community aspects of health education. The Conferences were also endorsed by the Governor's Office with Governor Thomas L. Judge proclaiming April 1 - 8, 1973 as HEALTH EDUCATION WEEK in Montana.

The Montana Division of the Mountain States Regional Medical Program was an active participant in the funding of the two conferences including the keynote speaker for this 1974 Conference.

The Joint Staff Committee to the office of the Superintendent of Public Instruction and Department of Health and Environmental Sciences in meetings with representatives of the Health and Physical Education Departments of Montana Colleges and University Units first originated the plan for a Montana Council on Health Education of the Public which would include school and community aspects. All state agencies and organizations interested in and in any way responsible for public health education met to discuss the idea. Following a special task force study, it was determined that there should not be a new organization formed but that the group would logically be a part of the Montana Health Association as a Health Education component. The first activity was sponsoring the two Conferences.

James Peterson, President
Montana Health Association
State Department of Health and
Environmental Sciences
Helena, Montana

COMMUNITY HEALTH EDUCATION: ITS PROMISED POTENTIAL

Alice Heath, Health Educator
Santa Barbara County Health Department
Santa Barbara, California

I, of course, regard my being here to help you start on your big task of implementation of a five year plan, as a distinct privilege. One only has to see the headlines of any local newspaper to be assured of the national crisis we are experiencing in the costs of medical care. An article in our Santa Barbara paper, April 7, reads "Health Cost Explosion Seen" ..... "Hospital charges to be up 16-17%, physician fees 9%, nursing home charges 14%." There may obviously be some political motivation for releasing this information at this time but I'm sure we'll all agree that costs are going up and if you don't have health insurance you're in trouble.

Take the example of the baby born in December in Woodruff, Arizona weighing 23 ounces. Medical science saved the child's life and later, the baby goes home and the parents get a hospital bill for $43,500! Family insurance paid $25,000 of the bill.

Here in Montana you have identified some health education needs. Last year's Governor's Report commented on patient education, venereal disease, lack of sex education, large percentage of illegitimate births, large amount of alcoholism and suicide. You are not unique in Montana in any of these problems. You have identified them. This will give something to plan from. Community health education will give ways of solving problems. Your method is a practical way.

We are attempting to show that community health education can help to solve this and other problems. Your conference is a method of group participation to share ideas and plan for what needs to be done. It is one of many methods that can be used in health education to get the problems "on the road."

The President's Report of the Committee on Health Education, published in 1972, has quite adequately pointed out the difference between the giving of health information (which many people think is health education) and the changing of behavior in people regarding some health practice, which is really health education. The latter definition is the one we will use.

Perhaps the best documented example of the gap between health information and change in health behavior has been illustrated in the data regarding the smoking pattern at the time of the Surgeon General's report and the situation at the present time. Certainly, there is plenty of information to show the harmful effects of smoking on health. Individuals (smokers and non-smokers) given a questionnaire regarding their knowledge of these dangers show that the smokers possess more correct information than the non-smokers. But still the smokers' smoke.

In fact, the number of persons smoking is on the increase rather than the decrease (especially in women) in spite of warnings on cigarette packages and other literature available. Yet we do know that some people quit and stay free of smoking. What is the ingredient that makes the difference - that changes the behavior?

At present, studies seem to show that: (1) The person must sincerely want to stop; and (2) in group settings where the smokers can exchange ideas with each other

and get the support of the group regarding their efforts to stop, that success is relatively high. Apparently the personal interaction makes the difference.

We could use this same example of the relationship between the giving of information and change in behavior in cancer prevention where the pap smear is known to be an early indicator of cervical cancer and yet many women avoid having the test. Why? There is also evidence to show that attention to a number of identified factors in heart disease; namely overweight, cholesterol, hypertension, stress, lack of exercise may lead to heart attacks. Recently, a friend of mine lost her husband, age 35, with an attack while playing golf. Two things come to mind - he did have some chest symptoms which he himself thought were the "flu." We need to help people to understand that any chest pain whether it be caused by indigestion, infection or heart disease should be suspected as heart disease and the individual should seek immediate help - go to an emergency room and have bed rest, not exercise on the golf course. The other overwhelming truth that came out in this case is the limited number of people who know cardio-pulmonary resuscitation methods. Ceretainly in a State like Montana where distances are so great between medical resources in an emergency, not only do you need a comprehensive communications network for dispensing ambulances, helicoptors, etc., and trained personnel to stabilize heart patients in the field as well as at the hospital, but you need much education of the private individual on self-help measures that can be practiced until professional help is available. Many lives would undoubtedly be saved.

In thinking of community health education we need to do a better job of evaluating what we are doing - what is it that changes the behavior and what barriers enter in to affect this change in behavior? Do we know why some programs work and some do not? Do we know that what we hope is education today changes behavior now or five years from now, and why is there a gap in some instances between some people finally changing their behavior many years hence.

Hypertensive clinics--very inexpensive to do. We know that medication can control hypertension. It doesn't cost much to take a blood pressure. You can train volunteers to do this. We have to rely on volunteers. We need to do a better job of education. We have to have measurable objectives to get money. We have to have methods of evaluation, cost benefits, it's part of the game. We can't count numbers at meetings for evaluation. There's no way of knowing if their behavior was changed. Actually, if health education is going to stay alive, we will have to show how expensive it is. We'll have to show what saving a life costs and saves.

I think we have some principles that can be helpful to keep in mind in planning change:

(1) Involvement of people in a program at the beginning does help. This is the so called "action research" approach where people help in collection and analysis of data, in the fact-finding and in the clarification of what they want to accomplish. People need to have some input in determining the needs (which often they know already); in mobilizing the resources to work on the needs; and to have personal satisfaction in accomplishing the solving of the problems. Perhaps one major rule to remember is - <u>involve people early</u>; <u>let it be their project</u>.

You remember Mabel Rickett, who is known in California as the "VD Kid." We have a problem of venereal disease in California the same as in Montana. Now our

State Department of Education has taken venereal disease education over as one of their priorities.

We started by running around showing films to schools. We realized we should be doing other things. We were doing what the teacher should be doing. We formed a VD coalition. We had a mixture of people in the community. We are no longer going into the schools. We work at the workshops. We have had most successful workships of around 30 teachers, administrators and 30 students. The young people went back to their schools and changed things. The teens attending were selected by students. They were kids that other kids would turn to in time of crisis.

In California, some of the teachers were afraid of losing their credentials if they mentioned VD. The coalition has a community awareness program.

(2) A second principle is an old educational truth - start where the people are, not where you think they should be. I like to give an example of a program that occurred many years ago but could happen today. A certain health department wanted to open up a baby clinic in a low-income Black neighborhood. The staff had decided that the mothers needed education regarding the bringing up of their children and that this clinic would help solve the problem. The only difficulty was that only one or two mothers brought their babies to the clinic, even though it was easily accessible and much publicity had been given throughout the Black community. Then someone discovered that there was a serious concern in this small Black community that had nothing to do with baby clinics. A stream running past the low-income housing was being polluted by raw sewage and children were playing in the stream. The people wanted to have their homes connected to the City sewer lines, but the property was so poor that it was politically impossible to interest anyone in extending the sewer lines. However, once a project of cleaning up the community - painting, removing literally tons of garbage, putting garbage cans with tops at strategic points began, they were able to increase the value of the property. They then experienced the voting privilege of circulating a petition and the sewage line went through. Health Department staff worked with the people to bring about this miraculous change and when the next baby clinic was scheduled, there was a full clinic. The people's needs had been met first and the needs as perceived by the staff were met later after trust had been established.

(3) A third principle of health education is reaching people at their own cultural level. Much has been achieved with OEO projects in developing outreach to people who previously were "not important," or "ignorant." In fact the entire next annual program of the American Public Health Association will be devoted to ways to reach minority and low-income groups more effectively. The farm workers health program, nationwide, where bilingual health aides were employed to relate on a on-to-one basis with the people, made a big difference to migrants and their health.

A little village in California, population 3,500, - 55% Mexican-American, had the highest tuberculosis case rate in the County in which it resided. An all-out education program was started using bilingual aides who could explain the new treatment of tuberculosis today (i.e., you don't have to die if you go to the hospital) and what the tuberculosis germ can do to the body. Just knowing the language alone is not enough. The health aide or community worker has to be accepted in the home and to accomplish this, the worker has to know the cultural values of

the family and expected practices that might be carried out - the role of the father, the medical superstitions, to name a few.

The story ended well. Within three years the case rate dropped from twelve new cases a year to none. We think education made the difference but certainly that education was not just passing out literature or showing films. That education involved a one-to-one relationship, a feeling of trust between people.

There is a sad footnote to this story. This particular county received national recognition for its innovative approaches in education. Gradually, however, the community workers began to be locked into the system. They were needed to help man (or woman) the clinics - to answer phones. Their schedules became tied to an IBM card so, instead of being able to go to the homes when the family was home from work or to talk to the people by phone at night, the rigid 8:00 a.m. to 5:00 p.m. hourly schedule had to be adhered to. the rule here is don't lock into the bureaucracy - keep the innovative processes going.

Patient education seems to be a popular educational approach in clinics, hospitals and doctors' offices. The two lead articles in the January-February issue of Health Services Reports are on patient education. The first is called "the potential of health education in health services delivery" - the second, "multi-disciplinary teams develop programming for patient education."

The classic example of patient education has been in the field of diabetes. For almost 50 years patients have been receiving education regarding their disease, its control, how to give their own insulin and how to test their urine.

The key person in patient education should be the private or clinic physician. He or she can set the stage for understanding the particular health problem at hand, be it control of a knowing heart condition; the establishment of a program to lose weight or even to understand that the disease the doctor is coping with may be terminal and preparations need to be made on the part of the patient and his family to face the inevitable outcome. However, with the expansion of health services we are finding that all personnel who come in contact with the patient are needed in the educational process. An example is in the care of the stroke patient where nurses, physical therapists, occupational therapists, speech therapists and volunteers all play an important role.

It is becoming apparent that patients have rights and that the hospital and clinic staff need to adjust their schedules to allow for the patient and his needs. In 1972 "A Patient's Bill of Rights" was adopted by the American Hospital Association. This includes the right of the patient to obtain complete information from his physician regarding his diagnosis and treatment and the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences if he refuses. I am thinking of stories I have heard of patients being sent to a teaching hospital because they "would get the best of consultant services for their particular problem." I also have heard of how the patient feels when a large group of young and eager interns, plus the specialists, discuss his case before him - and concentrate on the disease and not the person. someone described this feeling akin to "an insect impaled on a board" - helpless, non-participating, being analyzed for a specific problem, with no concern for the feelings of the

person. This paticular patient preferred a smaller, more intimate hospital without the great barrage of specialists because he felt more comfortable and actually more willing to cooperate in his own care.

A prominent internist asked to find out why so many patients who had entered the hospital for tests regarding their heart condition left the hospital before the angiogram or x-ray of the heart could be performed. The answer was found when a patient told of his experience. The cardiologist came to his bedside the night before the procedure was to take place and drew a complete picture of the heart and its blood vessels and what could be done to relieve pain if the test showed blockage of the vessels. The doctor then said, "I must tell you that this procedure carries with it risk - you could have a heart attack, a stroke, or even die while the procedure is being done. The chances are small but they exist. Here, 'sign the consent slip for the test'." The patient dressed and left the hospital. The anticipation and fear was too great. The education of the doctor did not take into consideration that the patient has rights and can refuse treatment if that fear is too great.

The British hospice concept was mentioned. It is a British method of helping people die with dignity. They are given no medication help, except to stop the pain. This can be used in any hospital. Someone must be with the patient when he dies and hold his hand while he dies.

So you go on now into your work groups - to try to work with your health problems and through community health education attempt to solve them. Whether it be education of patient in the hospital, teaching in the home, trying to help to ease the individuals entry into the delivery system and to help him stay there. Any of these are important, can influence life and most of all for you today can be a fulfilling experience.

THE BERKELEY MODEL *

Brad Morris, Director
Comprehensive Health Education, Helena Public Schools
Helena, Montana

Helen Delafield, Berkeley, California, School Health Educator, helped to develop the Berkeley Model. The National Clearinghouse on Smoking and Health is promoting it. The title is "National Elementary School Health Education Curriculum Project." To shorten the title, it was named the "Berkeley Model." The model is a teacher training model or pattern which other schools can use to design a health curriculum. There presently are six regional training centers. From the original 50 school districts, 200 schools are now participating after seven years.

Some of the reasons for success: students are enjoying their participation; they are taking information home to parents; and they find out that health education can be fun. The teachers feel one of the main reasons for success is associated with the students becoming involved.

The Berkeley Model is based on principles. Each unit is designed for a different grade. Unit 4 deals with the digestive system, the skeletal muscles, and nutrition; Unit 5, the lung and respiratory system; Unit 6, the heart; and Unit 7, the nervous system. Each unit is eight to ten weeks in length. Most teachers take more time because of the way they integrate this teaching with other subjects. During the ten weeks, integration occurs with as many subjects as possible.

The demonstration in the Helena fifth grades has indicated that fifth graders became very interested in the lung and respiratory unit. Various aspects of the model include 1) student involvement in many ways rather than by lecture from the teacher; 2) learning through various kinds of experiments; and 3) the climax comes when students dissect an animal lung. There are student developed methods. The program is ideal for presentation to PTA open house, etc. Parents are usually amazed with the project. Students pressure their parents to participate. Parents have served as volunteers in the project. The curriculum is much more personalized. Teachers are trained in using the materials. Sixty hours of training is given a small group of teachers who bring information back and train other teachers at home.

There is a good possibility of Helena becoming a training center. For information about this, contact Roy Davis, Project Chief, Community Program Development Division, Public Health Service, HEW, Center for Disease Control, Atlanta, Georgia.

*Summary of comments made by speakers

EXPLORING VALUES CLARIFICATION IN DRUG EDUCATION AND RELATED AREAS *

Bill Elliott
Office of the Superintendent of Public Instruction
Helena, Montana

Kids who get into trouble follow certain patterns. Kids who are successful have certain patterns. We can help them understand why they believe in certain things. If they are taking drugs, why do they believe in it. If they are taking part in athletics, why do they believe in that. In school we tend to stick to the right and wrong approach. Some schools require that teachers in the schools deal with value clarification. This will help children arrive at what they believe in and why.

Information is divided on three levels: 1) Facts; 2) Concepts; and 3) Values. In drug education we have been conducting social seminars. In drug education we try to determine or ask why people use drugs. The purpose of the social seminar is to develop community awareness. In the social seminar films, real life situations are presented. There are no actors. The films are taken of actual situations that are occurring. The seminar helps people understand where they are in relation to drugs.

These seminars will be available for one more year in the state. They have made good progress. Next year the plan is to work with colleges also and continue in the future with social seminars in the schools.

In the Social Seminars there is an attempt made to get down to the feeling level. There are several sets of films in the seminar package but in order to use the films, preparation and processing is needed. The films are usually not loaned or encouraged for use unless a person has attended a Social Seminar and knows how to use them.

*Summary of Comments made by speakers

TEACHER EFFECTIVENESS TRAINING *

James Van Meter, Counselor
Helena Public Schools
Helena, Montana

Teacher Effectiveness Training (or Parent Effectiveness Training) is teaching people to interact with other people so that there is a good, warm relationship. Specific methods of communication are discussed and practiced during the course such as the "I" message and "active listening." Active listening is listening to the other person so you will not turn him off. Listen to kids. Kids are often scared---they will first start talking about a peripheral problem to test to see if you will really listen., If they are not turned off, they will continue to get to their real problem which may be entirely different than was verbalized in the beginning.

Various problem solving methods are used when a problem exists between two people. First determine who owns the problem. Some methods used in solving the problem include the "Power Method"--where the teachers or the parents needs are met at the expense of the kid; and he or she feels badly. "Permissiveness"--the kids needs are met at expense of the parents or teachers which makes them feel badly. In problem solving where teacher and student actively listen to each other, no one loses. Problems which can be solved by TET or PET are those dealing with a relationship between two people.

All problems or differences cannot be solved but conversation can be opened such as a collision of values. Values pertaining to long hair, short dresses, smoking, etc., come within this category. A parent or teacher can be a consultant to a student on such values if they try to understand and respect the values of the student. However, if the parent or teacher tries to "put" their values on the student, they may be "fired" as a consultant and not be asked again for their ideas.

*Summary of comments made by speakers

LOOKING INTO THE FUTURE *

George Ineichen
Communications and Health Education Officer
Region VIII PHS
Denver, Colorado

As was recommended by the President's Committee on Health Education, A National Center for Health Education is being established in connection with the Center for Disease Control in Atlanta. It will be headed by Hod Ogden, who has been working with HEW. An Interagency Board within the Federal Government has been appointed. The National Health Council will be involved. A contract is to be let soon for a feasibility study as to how the National Health Education Center will be organized.

It is understood that the budget for 1975 will be two million dollars and in 1976 it will be between forty and fifty million dollars.

The Interagency Board will establish guidelines within the agency. It is planned that there will be forty positions for health educators in the Center the first year. Many of these will be National Smoking and Health Personnel who are to join the organization with their project. In 1976, there will be other health educators employed. It is not known whether health educators will be assigned to states or regions.

A conference on "The Federal Focus on Health Education: Needs and Priorities," is planned for June with the State Directors of Health Education. Center plans should be firmed up by that time.

George stated, "For the first time in a long time, I am enthusiastic about the future of health education. The future looks extremely bright."

Children's Television Workshop, the producers of "Sesame Street" and the "Electric Company" are going into health education. They have seven million dollars to make a series of 26 TV shows to be aired in prime time this fall. They will be competing with regular prime time programs and hope to build quality shows that will gain recognition. The shows will be built along the lines that "VD Blues" was done. After the tapes are shown and used on TV they will be given to educational stations. Provision will be made for people to sit in and recieve calls from the public when the showings are presented. "These programs are overwhelming--they are excellent. We hope to have some participation in their development in this Region."

*Summary of comments by speakers.

SUMMARY
FIRST GOVERNOR'S CONFERENCE: NEEDS DETERMINED

THE FIRST GOVERNOR'S CONFERENCE ON HEALTH EDUCATION was held in Helena, April, 1973 at the Colonial Hilton. Approximately 150 persons from throughout the state attended the conference, including teachers, school administrators, counselors--both elementary and high school--college professors, college students, nurses, physicians, hospital workers, hospital in-service directors and administrators and others interested in health education.

The objectives of the conference were to place emphasis on community health education and school health education. Four areas of health education were explored through small group sectionals. The four topics were:

Socially Sensitive Health Education Areas

Venereal Disease; Sex Education; Pregnant Teenager; Addictive Drug; Alcohol, Tobacco Education.

School Health Education

Health Education Models; Environmental Health Education; Adult Education Programs; School Health Education Curriculum; Dental Health Brush-In.

Community and Family Health Education

Family-Centered Health Education; Voluntary and Professional Health Organizations; Patient Education, Hospital-Based Health Education Programs; Health Education in Comprehensive Health Planning.

Higher Education and Health Education

Teacher preparation; Health Education in Continuing Education Programs; Education for Health Occupations; Extension Courses in Health Education.

Charge to each Group Sectional:

Determine the top four priorities--either from those listed or others suggested. Discuss each of the four priority subjects from these aspects.

What is the situation at present?
What should it be?
What is needed?

Group Sectional Findings

Group I - Socially Sensitive Health Education Areas

Leader:	Ann Seibel	Resource:	Paul Babbitt	Jack Shevalier
			Dee Capp	Bob Solomon
			Rev. Ostrander	George Swartz
			Don Pratt	Joe Rothstein, Ph.D.
				Roy DeLong

SUMMARY - FIRST GOVERNOR'S CONFERENCE

Group 1 - Socially Sensitive Health Education Areas (cont.)

Topic: A. "Venereal Disease"

What is the situation at present?

--GC (gonorrhea) increasing greatly, especially in 14-19 age group. About one in ten cases reported by physicians.

--Competency program being developed for teachers to help them feel comfortable in discussion on VD.

--Visits to schools--films and question/answer periods with large and small groups.

--Hot Line established in the state for VD.

--Some community education--TV, newspaper coverage.

--Contact tracing for syphilis.

What should it be?

--Comprehensive school health education program K-12, with qualified teachers.

--Eradicate VD.

--Compulsive blood and urine test, penicillin to all who need it.

--Community awareness and education
  adult education
  information to pre-natal care classes for parent education--including help in raising children.

--Pre-natal test for GC as well as syphilis.

--Family planning clinic as another education route.

What is needed?

--Line item budget for health education funding.

--Appropriate materials--localized for communities.

--Attitude test use.

--Curriculum guidelines and consultation from state--many services are available but communities and professionals are not aware of them, therefore services are not used.

--Better communication as to what each other is doing in health education, leading to coordinated efforts--state and local levels.

--Central clearinghouse in a state department.

--Community awareness and development.
  awareness of need for education
  leadership needed--help communities identify needs--use people active in community, e.g., capitalize on industry and energy of active women not employed outside of home

--Qualified personnel.

--Value clarification.

--Education for doctors and other medical personnel.

--A better method of finding gonnorrhea early.

B. "Sexuality and Family Planning Education"

What is the situation at present?

--A survey--three years old--of public and private schools, senior and junior high level, indicated only 28% of schools had a person responsible for education on sexuality.

--No ideally coordinated program for K-12 in entire state.

--Very limited courses at college level relating to sexuality and family planning.

--State government refuses to get into family planning with funds.

--Legislators, parents, government at all levels provide no funding for schools for educational programs.

--Training includes:

1. Sexuality workshops, one week in summers for small number of teachers
2. MSU Family Life Dept.
3. In-service programs provided by SDH&ES on request.
4. Some local resources in mental health clinics, family planning clinics, etc.

--Widespread misunderstanding as to need for and the basic information that individuals require for adequate decision making.

What should it be?

--Have all adults informed.

--Use post-partum time to impart information on family planning to all mothers.

--A K-12 program in all schools with opportunity for further education on college level.

--Fit the program to the needs of the community.

--Teach need for "sexual responsibility."

--Need for making "proper decisions."

--Clear understanding of <u>words</u> by everyone.

What is needed?

--Analyze situation for best use of limited funds.

--Lack of definition; de-emphasize "sex" a loaded word--many people think of physical aspects.

--A course that will provide "decision making."

--To learn how to cope with people.

--To change "Raquel Welch" image of "perfect partner."

--To change emphasis in communicative advertising.

--Parents to provide sex education.

--Involve parents and community in joint family-school sexuality education program.

--Well informed and informative doctors.

--Responsible people throughout the school system--not afraid of sex.

--Need the "open" or unique person in places where contact is made when students have special problems such as pregnancy.

--Good sex education programs that pay what they are worth.

--Methods or usage of informing parents on how to communicate--example: coffee groups to discuss at community levels.

--Need for personal values to be expressed.

--Need clarified values.

--To make time available for sexuality and family planning education.

--Total education of parents about their own sexuality.

--A comprehensive K-12 program including:
emotional, sociological, psychological, biological aspects.

--Higher education needs to accept responsibility for teaching confident and competent teachers to teach sex or sexuality education including family planning.

C. "Pregnant Teenagers"

What is the situation at present?

--Education of pregnant girls is usually restricted:
Schools do not allow pregnant girls to attend school.
Girls need to drop out before and after childbirth.

--Unwed mother or couple has no economic stability in most cases.

--Prenatal care is usually started late in pregnancy; therefore, weight problems, dietary and other problems not given attention.

--Childbirth in the teens is high risk to both mother and child. Teenagers have more difficulties in childbirth and there are more chances for having caesarian section.

--Premature and underweight babies more prevalent with teen mothers.

--Emotional hazards greater--having a child when not prepared and having to go through with pregnancy and childbirth before prepared to do so.

--Tendency to repeat unwed pregnancy unless adequate counseling, and help to the girl and her family.

--Many girls have relied on Aid to Dependent Children for support when keeping their children. The number of young mothers getting ADC has doubled in the last two years.

--More teenagers are keeping their babies.

--Incidence of divorce for those who marry under 20 is great. Many who marry early are pregnant before they marry. The first two years of early teen marriages double problems of divorce.

--Community attitude toward unmarried mothers, especially those who keep their children, is generally negative.

What is needed?

--Give parents information so they may be able to begin with very young children in giving them proper information and attitudes.

--Provide a good system of education where young people get information on courtship and marriage and family planning.

--Teenagers should have knowledge of child development, care of children, and what is needed to be a good parent.

--An educational system to give young people--K-12--information about their own sexuality, what it means to be a parent, how to take care of families, young babies, and foods needed by a family including a tiny baby.

D. "Addictive Drugs, Alcohol, and Tobacco Education"

(No report was received from this section)

Group II - School Health Education

Leader:	John Dayries	Resource:	Oral Behunin	Ed Eschler
			Jim Grant	Mr. Palmer
			Jack Terrill, DDS	Sharon Weatherson

What is the situation at present?

--Lack of actual teacher education training within health professional training programs.

--Schools targeted in on nurses since they were main resource people available.

--Health education has been crisis oriented.

--Knowledge about individual and family health is lacking among the adult population.

--Kids have a negative attitude about health services.

--We are using a negative approach in health education.

--Anticipation of problems in five to ten years is impossible.

What should it be?

--Some teaching skills developed within health professional training.

--More counseling of health professional students so they have an understanding of various options available to them.

--Work experience in their field for teachers of health.

--Adequate budgeting and coordination of continuing education and extension courses in health education.

--Performance based criteria established for health professionals and teacher education-provide mobility and utilization.

--Focus of school health education should include evaluation and change; problem solving techniques; behavior and attitudes; and teaching of values.

--Teach prevention of disease and disability.

--Time and personnel to teach permanent prevention for life in dental care.

What is needed?

--Teaching option offered to health professional trainees.

--Individual awareness of health professional of the "needs" in the teaching area.

--Possibility of completing a teaching minor with whatever health professional training the individual is taking.

--Methods of changing behavior patterns.

--Re-humanize education.

--Accident prevention to include how to handle minor accidents; first aid supplies in the home; emergency medical courses to help save lives at the scenes of accidents.

--Education on accident prevention must be continuous and realistic.

--Environmental education coordinated with health education.

--A clearinghouse and more research for information on health aspects of consumer education.

--Nutrition education to include correlation with the home to reinforce instruction.

--Health people to support and help initiate a school health education curriculum-define the area, start the program, sell the school administration, and get community support.

--A positive approach to health teaching.

--Continuing education courses offered at university level in teacher training and skill training.

--More communication between health occupational professionals within health care industry and educational institutions.

Group III - Community and Family Health Education

Leader: Beatrice Kaash

Resource:

John Connors	Earl Thomas
Jim Foley	Patricia Thorpe
Sandra Green	Robert Johnson
Stan Rosenberg	Leonard Brewer, M.D.
Jack Lewis	Marylor Lahey

A. "Patient Education, Hospital and Health Agency Based Patient Education Program"

What is the situation at present?

--In a number of hospitals there are patient education programs in stroke, diabetes, ostomy care, education for parenthood, smoking clinics, obesity programs, post partum OB-GYN programs, psychiatric and mental hygiene and other health programs.

--Montana's hospitals are small institutions, only six to eight 200+ beds that have full time clinical nursing specialists or nurse clinicians, pharmacists, physical therapists, inhalation therapists, etc.

--There are ten local home health agencies but no organized out-patient clinics.

--A limited number of established patient prescriptions for patient education.

--There arise questions of cost--e.g., who pays for patient education--what about third party payers?

--Few teams address themselves to the needs of groups of patients with similar educational needs.

(The above list is incomplete but developed from the knowledge of those in the group.)

What should it be?

--Complete riddance of the contingency fee--end law suits.

--Standardized professional education with uniform qualifications country wide.

--Begin after care planning at time of admission of everyone and include primary and preventive care and rehabilitation plans utilizing all available resources.

--Maximum utilization of hospital facility.

--The hospital department of education be established on the same administrative level as other departments, not a division within nursing.

--All hospital personnel be motivated for teaching.

--Widespread support of home health agencies with emphasis on patient and family teaching.

--Public health education regarding use of available resources of professional and voluntary organizations and agencies and personnel.

--Adequately funded Hospital Learning Centers.

What is needed?

--Education of professionals in health and adult education methodology.

--Ambulatory day care centers with emphasis on patient education.

SUMMARY - FIRST GOVERNOR'S CONFERENCE

--Comprehensive health planning meetings of consumers and providers to assess needs and publicize available resources.

--Willingness to listen to what the consumers feel are their health education needs and not to superimpose learning needs.

--Need for health professionals to learn to communicate with consumers and identify their own continuing education needs in this area.

--Provide for teams of consumers and providers to go into small hospitals and communities to assess needs, recognizing the dangers that expectations of service may not be met; that individual awareness and attitude changes are essential.

--That hospitals establish departments of health education on the same administrative level as other departments.

--Develop a means whereby small hospitals can meet the problems of patient education without having appropriate staff members, e.g., dietitian, physical therapist, clinical pharmacist, etc., by developing the expertise of hospital learning centers to meet the challenge of patient education in small hospitals.

--Develop systematic communication through the mechanism of CHP.

Education is a three-way street.

--Staff to be knowledgeable of content and methodology of patient education.

--Patient knowledge to change his behavior and meet his needs for optimum health from primary through after care rehabilitation and prevention.

--Family and community work with the community to accept behavior of the patient and awareness of resources and referral system.

B. "Health Education in Comprehensive Health Planning"

What is the situation at present?

--CHP has a statewide and regional organizational structure in operation now. Some counties have active councils and others are forming.

--Presently CHP functions to prevent duplication of services within communities.

--It is a funded mechanism that has the potential for state wide coordination of health education.

--It does not operate programs.

--It is a new agency.

What should it be?

--There is a possibility that Regional Medical Program may be phased out. If this becomes fact, CHP may be the organization to fill the void left by RMP.

--Health education needs in the planning stage could be looked at but not implemented.

What is needed?

--A coordinating body to identify health education needs and resources within the state. Possibly CHP would be this body.

--Members of the CHP board should be educated regarding the functions, activities, objectives, etc., of CHP.

--Development of objectives for process of awarding "certificate of need;" to facilitate realistic and honest appraisal of what actually should be funded for buildings, equipment, etc.

--There should be better dissemination of CHP findings within the state.

Group IV - Higher Education and Health Education

Leader: Esther Lantz Resource: Barbara Crebo George Shroyer
Tom Whiddon C. Brent Poulton

A. "Continuing Education and Extension Courses"

What is the situation at present?

--University level--we do have extension divisions, but course content as relates to health education is limited.

--Vo-Tech System.

--Regional Medical Program (Unknown future).

--Montana Medical Education and Research Foundation (non-profit group providing educational programs in all health professional areas).

--Many professional and voluntary organizations provide education courses or programs.

--Hospital based in-service and learning centers.

--Western Montana Educational Council (has representatives from all health professional groups).

--Correspondence courses from some universities in the Northwest.

--Comprehensive Health Planning Program.

(There are many more we did not list.)

What should it be?

--Coordination of activities.

--Changing to a public concept of wellness to replace illness.

What is needed?

--Coordination of continuing education efforts currently being made available and possibly through the state's Office of Superintendent of Public Instruction by filling the position of Supervisor of Health Education.

--Coordination of health resources available.

--To create an awareness of the need for health knowledge in the minds of the general population.

--Planned programs in health and family life to include the total population, from pre-school through adulthood.

--Structured health education for groups working in health; e.g., social workers.

--Career ladder concept for certain health occupations; e.g., nurse aide to LPN, LPN to RN, etc.

--Channeling additional monies into the preventive side of health.

B. "Health Occupations"

What is the situation at present?

--Carroll College has new program on Nursing in the Community to expose students to the total health field, not limited to hospital. This is a core curriculum for health occupations.

--Vo-Tech has open curriculum core with five options. Home health aide, nurse ass't., psychiatric aide, LPN, etc. All must take basic core then specialize in:

Basic Science	Nurse Patient Relationships
Vocational Relations	Licensing

Using team approach in instruction; instructor has classroom and clinical experience.

--University has core program for nursing and then moves into area of special interest.

--Nursing has several master programs.

What should it be?

--Core curriculum elements common to several health occupations.

--Instructors need field experience to expose them to problems in the field and those in field should have some academic exposure.

--Improved career counseling for students uncertain of direction they should take.

What is needed?

--Identification or a re-definition of health occupation roles.

SECOND GOVERNOR'S CONFERENCE: GROUP SECTIONAL RECOMMENDATIONS

Group I. Socially Sensitive Areas Section - Bob Loughrie, Group Leader

RECOMMENDATIONS:

1. VD education should begin in the seventh grade and should be preceded by a progressive and inclusive health education curriculum in the first grade (or kindergarten if they are operating in a community).

2. VD should be taught as a communicable disease.

3. Parent-teacher coordination should be affected when teaching about VD in the classroom. Parents and teachers should have adequate competencies in VD facts and figures.

4. School health education should be taught by a qualified health educator and the school's accreditation should be effected by this standard.

5. More involvement of parents should be sought to make them aware of the overall health curriculum.

6. The SDHES should meet with teachers to explain the new health guide and help them to implement it.

7. A comprehensive and progressive health curriculum should be taught in grades K-12 in every school in Montana.

8. The school's accreditation should be dependent upon the satisfaction of t. the previous recommendation.

9. The office of the Superintendent of Public Instruction should hire a supervisor for health in Montana's schools.

10. Morals and values should be treated in the classroom as a part of the sections on VD, sexuality, and other socially sensitive areas.

11. The role of the teacher should be to cover the entire scope and depth of sexuality and to act in a nonjudgemental manner.

12. Courses, workshops, seminars, etc., in values clarification should be made available to teachers. The SDHES (State Department of Health and Environmental Sciences) and OSPI (Office of the Superintendent of Public Instruction) should assume leadership roles regarding these sessions.

13. Deans of schools of education should be informed as to what transpired at the Governor's Conference on Health Education.

14. Conference participants should be utilized in the distribution and explanation of the health guide whenever possible.

15. Quality contraceptive information should be provided in the classroom.

16. Parent-child communication should be stressed.

17. The pregnant teenager has a need for information regarding reproduction and also a higher degree of self-awareness (goals, values, needs).

18. Quality counseling should be easily available to the teenage father.

19. Socially sensitive areas of the health curriculum should be taught in a co-educational setting.

Group II. School Health Education - Group Leaders: DeeAnna Stalnaker
Bob Moon
Oral Behunin

RECOMMENDATIONS:

1. To establish a position of Health Education Supervisor in OSPI.

2. To encourage health education in local communities so as to provide a curriculum of such in the schools.

3. To assist in the organization of local communities re: the curriculum demonstration project of SDHES.

4. To promote legislation that would require every school in the state to offer a health education curriculum.

5. To encourage at the college level that teachers in education take a minimum number of health courses to prepare for some level of confidence in dealing with the subject.

6. <u>How to implement a district-wide, K-12, Health Program.</u>

   A. Form temporary committee which will appoint a health council to consist of:

      1. a medical doctor
      2. a (D.D.S.) dentist
      3. an administrator in the school system
      4. a public health nurse
      5. a city/county health official
      6. a P.T.A. officer
      7. a member of the local teachers association
      8. a mental health representative (e.g., counselor or psychologist)
      9. interested parents
      10. interested laymen

   B. The committee should:

      1. discuss health needs of the community
      2. discuss need for school health program
      3. discuss who the most influential power structure would be (who would help or deter program implementation)

4. decide what type of guidelines the K-12 program would follow
5. decide how much funding would be necessary to implement program

C. Follow an action plan, form committees of the council to:

1. investigate other schools' health programs
2. investigate community health needs
3. to get students, teachers, and parents' opinions
4. educate community on the importance of a health education program
5. locate and sell the value of health education to the school system's power structure (to school board and administrators)

Group III - Community and Family Health Education - Group Leader: Scottie Byerly

RECOMMENDATIONS: (These recommendations speak directly to only some of the problems discussed but have potential for impact on several.)

1. Recommend that CHP develop health council concept at the local level and use these councils to attack local health problems. Councils should involve Boards of health, health professionals agencies; and

2. that communities, through local health councils, prepare directories of resources, categorized by health problem or condition, and cross referenced by agency. Local health councils to compile information and send to an existing central coordinating agency. The latter to coordinate compilation of area and state information and provide it to local health councils. Develop a program for distribution of use including methods--to include any personnel in facilities.
Material in directories to be continually updated.
(see this as helping with involvement, awareness, use, coordination, etc.);

3. use of media for all aspects of health education with use of human interest stories. The State Department of health and Environmental Sciences have a public relations program;

4. support the development of health information and referral centers;

5. greater involvement of physicians in all aspects of health education programs;

6. that more legislators be involved in health related conferences as well as health issues;

7. support pending legislation to utilize effectively the services of paramedical personnel; and

8. recognize the need for continued health and patient education and support continual study of it. Support the concept of a supervisor of health education in the State Department of Public Instruction.

SECOND GOVERNOR'S CONFERENCE: GROUP SECTIONAL RECOMMENDATIONS

Group IV Higher Education and Health Education

Group Leaders: Barbara Crebo
Tom Kelly

RECOMMENDATIONS:

1. Supervisor of Health and Physical Education in Office of Superintendent of Public Instruction. The position to be filled by July 1, 1974. Direct the Governor's Conference Executuve Committee on Health Education designate representatives from the Montana Health Association and the Montana Physical Education Association to meet with the Department of Public Instruction to discuss the qualification of the future Supervisor of Health and Physical Education;

2. that the Executive Council of Governor's Conference on Health Education approach the Comprehensive Health Agency to:
   a. compile, publicize, and disseminate a statewide directory of health resources available; and
   b. compile, publicize, and disseminate information on health related activities on a weekly basis to community information media;

3. Health and Family Life educational program: The Family Life Sciences Option in the Home Economics curriculum at Montana State University provide training that safisfies this recommendation;

4. Direct that the Executive Council of the Governor's Conference on Health Education recommend to the Governor's Commission on Post Secondary Education that the Career Ladders concept for certain health occupations be explored and encouraged;

5. Direct the Execuitve Council of the Governor's Conference on Health Education appoint a committee composed of a representative from each of the following areas: Education, Medical, Dental, Nursing, Community Health and a School Administrator to appear at the School Administrators' Annual Meeting to explore present and future needs of health education at all levels of elementary and secondary education.

PLAN OF ACTION AND FINAL RECOMMENDATIONS

1. On the recommendation of Oral Behunin that a committee be formed to recommend representatives that should be on the MHA Health Education Section, several people volunteered or were suggested for the "forming" committee. (See #4 below)

2. Taking recommendations of the conference to the Governor and requesting his endorsement. Copies of the recommendations should go to the School Board Association, to a state PTA Meeting and to the Montana Education Association Executive Committee meeting.

3. Explore the possibility of funding from the new Health Education Center. Financial support would be needed in organizing the committee, especially for some travel expenses for committee members who live out of Helena.

4. The "forming" committee met immediately following the adjournment of the conference. Present at this meeting were Al Feldner, DeeAnna Stalnaker, Melody Merenz, Fairview High School, Dr. Terrill, Roland Fisher, Oral Behunin, Maxine Homer, Don Pratt and Bill Seabrook. This committee suggested several agencies and organizations or groups to be represented on the Executive Committee. It was also suggested that each representative select an alternate who could attend the executive committee meetings in their place. The following agencies or groups were suggested, plus recommended people from these agencies:

   Nurses, Carol Walter, Deaconess Hospital, Great FAlls
   Hospital Association, Roland Fisher
   Third Party Payers, Bill Seabrook, Great Falls
   College Level Students
   Physicians, Dr. Haling, Pediatrician, Great Falls
   Dentists, Dr. Terrill, Helena
   Comprehensive Health Planning, Mary Jane Crigler, Helena
   Colleges and University Units, Oral Behunin, Bozeman
   Secondary Schools, DeeAnna Stalnaker, Helena
   High School Students, Melody Merenz plus two Helena High Students
   Voluntary Health Agencies, Lucille Paddock, Lung Association
   School Administrator, Maynard Olson and Brad Morris
   Office of Superintendent of Public Instruction, Barbara Crebo
   Legislators, Robert E. Lee, Butte, and Elmer Flynn, Missoula
   Indian Health Service, Arthur Lee, Browning; Don Swartz, Billings
   State Alcohol and Drug Programs, Governor's Office
   State PTA, Lyda Wheeler, Kalispell
   Bureau of Health Education, SDHES, Maxine Homer
   Montana Health Association, Don Pratt
   Local Health Department, Frances Alves, Missoula
   Western Montana Council on Health Education, Dorothy Hoshaw

5. It was suggested that a committee including high school students meet with the Superintendent of Public Instruction and make recommendations concerning the qualifications of the person to be hired as Supervisor of Health and Physical Education. Maxine Homer was asked to call the Superintendent of Public Instruction and alert them that a committee will want to meet with them as soon as possible to carry out the above recommendation.

6. The suggested executive committee will meet May 1, at 10:30 a.m. until 3:30 p.m., Conference Room, 9th Avenue Building.

Follow up meeting

The Executive Committee met in Helena, May 8, 1974, with Clark Fowler, representing Mrs. Delores Colburg, State Superintendent of Schools, who could not be present. Twenty persons from the Committee attended, including several high school students.

The recommendation from the Governor's Conference that the new Health and Physical Education Supervisor have training and experience in health education as well as physical education was relayed to Mr. Fowler. Mr. Fowler explained that the Statute requires that a physical education supervisor be employed (it does not include a health education supervisor). The new supervisor will be employed July 1, 1974. A developmental physical education program is beginning at the elementary level and the supervisor will be much involved with this program. It is doubtful if there will be too much time for other activities.

There was discussion from the group concerning the need for health education in the schools. Mr. Fowler mentioned the many areas of interest that are requesting leadership such as social studies, etc. Presently, 20 schools are being assisted in the School Community Assistance program. Next year large districts want to get involved.

The question was asked, "what is the best way for a group in the state to show influence in getting a health education supervisor?" It was also suggested that since the supervisor being employed came about through legislation, perhaps that would be the best way to proceed.

Mr. Fowler commented that legislating curriculum is not appreciated by educators as a whole and by the OSPI.

It was suggested by Mr. Fowler that groups such as that one continue to promote interest in health education. He felt the ultimate would be to have a full-time qualified health educator. He assured the group that he would relay their concerns to Mrs. Colburg and as soon as the supervisor is hired he would talk with him and inform him of the interest. Mr Fowler felt that the reason there is not more interest and more activity in health education is because of the assumption that most children are healthy.

Including health education as a separate subject for accreditation was also discussed. The State Board of Education makes final decisions on accreditation and changes are only made every two years. Request for changes should be submitted one year in advance.

There was also discussion of endorsement for health education teachers. There are 90 areas of endorsement and it becomes a problem when there are too many details.

A junior from Great Falls High School gave an excellent discussion on why good health education is needed especially in junior and senior high schools. He brought out the problem of venereal disease and teen pregnancies and the large number of students who drop out of school. He felt that good health education would prevent many of the problems of teenagers.

PLAN OF ACTION AND FINAL RECOMMENDATIONS

A short business meeting was held. Oral Behunin, MSU and Brad Morris, Helena Schools, agreed to be Co-Chairmen of the Executive Committee. Bob Loughrie was chosen secretary. It was suggested that the next meeting be held in September, 1974.

* * *

REPORT TO THE GOVERNOR
by Roland D. Pratt
Committee Chairman

The Governor's Conference on Health Education has met in two annual sessions and recommends the following be implemented to strengthen Health Education in Montana.

1. Be it resolved that the Executive Committee of the Governor's Conference on Health Education meet with the Superintendent of Public Instruction to encourage her to fill the position of Health and Physical Education Supervisor. Be it further resolved that the committee make strong recommendations to the Superintendent that one of the qualifications for the individual appointed, be a strong background in Health.

2. Be it resolved that the Executive Committee of the Governor's Conference on Health Education send a letter to the post-secondary education committee of the Board of Regents to the effect that continuing education in health education be continued and expanded so as to give adequate training to those individuals involved in Health Education.

3. Be it resolved that the Comprehensive Health Planning Agency of the State Department of Health and Environmental Sciences be directed to develop health councils at the local level, and also to compile, publish and disseminate a state wide directory of health resources.

4. Be it resolved that the State Department of Health and Environmental Sciences develop a public relations program aimed at informing the public of the health services available, the manner in which an individual can enter the health service delivery system and that health information and referral centers also be developed. This program should utilize the services of private physicians, legislators, para-medical people, volunteer agencies and consumers.

5. Be it resolved that there be developed a health curriculum guide that can be utilized from kindergarten through grade 12. This guide should not be a "rote-step" manual, but should refer to ideas, concepts and reference materials available for health instruction.

6. Be it resolved that the Executive Committee of the Governor's Conference on Health Education approach the accreditation committee of the Board of Regents with a proposal on minimum qualifications for health instruction accreditation. Be it further resolved that this proposal state that individuals teaching health have health instruction at a college level. Be it further resolved that the university system develop a curriculum for a major in health education.

7. Be it resolved that the Executive Committee of the Governor's Conference on Health Education recommend to the Governor's Commission on Post Secondary Education that the Career Ladders concept for certain health occupations be explored and encouraged.

A P P E N D I X

A. CONFERENCE ANNOUNCEMENT

Announcing. . . . GOVERNOR'S CONFERENCE ON HEALTH EDUCATION
To be held April 15, 16, 17, 1974 at the Colonial in Helena

The first conference brought out many areas that needed further in depth study. Much work has been done during the past year in attempting to bring these areas into focus. The Second Governor's Conference will decide where we are at and the direction we should go. At the conclusion of the conference, recommendations will be made and presented to the Governor for his consideration.

GOVERNOR'S CONFERENCE ON HEALTH EDUCATION

Attention will be given to several subject areas, including:

Socially sensitive health education areas--sex education, pregnant teenagers, V.D. education.

School health education--environmental health education, adult education, school health curricula.

Community and family centered health education--patient education, health education in Comprehensive Health Planning, voluntary and professional health organizations.

Higher education in continuing education programs, and education for health occupations will be featured.

The survey of the school health education programs will be presented and discussed.

The Governor's Conference on Health Education is being sponsored by the Health Education Committee of the Montana Health Association.

All Montana citizens are invited to attend the entire conference, which begins with a luncheon meeting April 15, 12:30 p.m. conference ends at 1:00 p.m., Wednesday, April 17. The registration fee includes the price of the Monday luncheon. ALL REGISTRATION FORMS MUST BE RECEIVED BY MARCH 29.

B. REGISTRATION FORM

GOVERNOR'S CONFERENCE ON HEALTH EDUCATION
April 15, 16, 17, 1974

NAME_____

ADDRESS_____

CITY_____ZIP CODE_____

Affiliation, If Any_____

REGISTRATION FEE OF $10.00 IS ENCLOSED: Check_____ Cash_____

(PLEASE MAKE CHECK PAYABLE TO THE MONTANA HEALTH ASSOCIATION)

A banquet is planned for the evening of April 15, 1974. The Wednesday closing session will be a luncheon. All meal functions will be at the Colonial. Please indicate which meal function you will attend:

Banquet ($4.50) yes_____ no_____ Wednesday luncheon ($2.75) yes_____ no_____

FOR RESERVATIONS AT THE COLONIAL

Name_____

Address_____

City_____State_____

Firm_____

Arrival Date_____HR_____AM PM

Departure Date_____HR_____AM PM

CIRCLE ACCOMODATIONS DESIRED:

Double Double--
Double Occupancy ---------- $17.00
Studio Queen--
Single Occupancy ---------- $16.00
Studio Queen--
Double Occupancy ---------- $19.00
Suites--
Fireplace-King ---------- $20.00-$35.00

Roll-a-Ways ---------- $ 3.50
(Some rooms accomodate 4 people)

All reservations are held until 6:00 p.m. Should your arrival be after 6:00 p.m., you may send a deposit to guarantee accomodations.

Accomodations at other motels to be arranged on your own.

Please return this form and registration fee to:

Don Pratt
Cogswell Building
Helena, Montana 59601

C. PROGRAM AGENDA

Montana's Second State-Wide

GOVERNOR'S CONFERENCE ON HEALTH EDUCATION
April, 15, 16, 17, 1974
Colonial-Hilton Convention Center
Helena, Montana

MONDAY

11:00 a.m. - 12:30 p.m.	Registration
11:00 a.m. - 12:15 p.m.	Meeting of Facilitators and Recorders Capitol Club Room
12:30 p.m.	Luncheon Meeting -- Don Pratt presiding
1:00 p.m. - 1:15 p.m.	Welcome: from the Governor's Office from the Montana Health Association Jim Peterson President
1:15 p.m. - 2:00 p.m.	Keynote Address Community Health Education: Its Promised Potential Alice Heath
2:00 p.m. - 2:40 p.m.	Report of the Governor's Committee Don Pratt DeeAnna Stalnaker Ardyce Alton
2:40 p.m. - 3:00 p.m.	Break
3:00 p.m. - 4:30 p.m.	Group Sessions
4:30 p.m. - 4:45 p.m.	Meeting of Facilitators

TUESDAY MORNING

Presiding: Roland Fisher

9:00 a.m. - 10:00 a.m.	Teacher Effectiveness Training Jim Van Meter
10:00 a.m. - 10:15 a.m.	Break
10:15 a.m. - 12:00 noon	Group Sessions
12:00 noon - 1:30 p.m.	Lunch (on your own)

TUESDAY AFTERNOON

Presiding: Lucille Paddock

1:30 p.m. - 2:30 p.m.	Exploring Values Clarification in Drug Education and Related Areas Bill Elliott
2:30 p.m. - 3:15 p.m.	The Berkeley Model Brad Morris
3:15 p.m. - 3:30 p.m.	Break
3:30 p.m. - 4:30 p.m.	Group Sessions

4:30 p.m. - 5:00 p.m.	Meeting of Facilitators
6:30 p.m.	Banquet Master of Ceremonies - Brad Morris "Looking Into the Future" - George Ineichen Mod Moms Dancing Girls

WEDNESDAY

Presiding: Maxine Homer

9:00 a.m. - 10:30 a.m.	Group Meetings
10:30 a.m. - 10:45 a.m.	Break
10:45 a.m. - 11:30 a.m.	Facilitators Meeting
11:30 a.m.	Lunch Facilitators Panel Report Finalizing Plan of Action
1:30 p.m.	Adjourn

PROGRAM PARTICIPANTS

ALTON, Ardyce, Nurse, State Department of Health and Environmental Sciences, Helena, MT 59601

BEHUNIN, Oral, Ed.D., Assistant Professor, Department of Health and Physical Education, Montana State University, Bozeman, MT 59715

BYERLY, Frances (Scottie), Ph.D., Community Volunteer, Lewistown, MT 59457

CREBO, Barbara, Office of Superintendent of Public Instruction, Helena, MT 59601

ELLIOTT, Bill, Drug Education, Office of Superintendent of Public Instruction, Helena, MT 59601

FISHER, Roland, Montana Hospital Association, Helena, MT 59601

HEATH, Alice, Health Educator, Santa Barbara County Health Department, Santa Barbara, CA 93102

HOMER, Maxine, Health Education Bureau, State Department of Health and Environmental Sciences, Helena, MT 59601

INEICHEN, George M., Communications and Health Education Officer, Region VIII, Public Health Service Center, Denver, CO

LOUGHRIE, Bob, Health Educator, State Department of Health and Environmental Sciences, Helena, MT 59601

MORRIS, Brad, Director of Health Education, Helena Public Schools, Helena, MT 59601

PADDOCK, Lucille, Program Development Consultant, Montana Lung Association, Helena MT 59601

PRATT, Don, Public Health Advisor, State Department of Health and Environmental Sciences, and Chairman, Governor's Committee on Health Education, Helena, MT 59601

STALNAKER, DeeAnna, Teacher, Helena Senior High School, Helena, MT 59601

VAN METER, Jim, Counselor, C.R. Anderson School, Helena, MT 59601

SESSIONS AND GROUP FACILITATORS

Socially Sensitive Health Education Areas
Bob Loughrie

School Health Education
Oral Behunin

Community and Family Health Education
Frances Byerly

Higher Education and Health Education
Barbara Crebo

Charge to groups:

From needs developed last year, this year is for action:
Implementation
Long range--Five year plan
Evaluation

SPECIAL RESOURCE PEOPLE

Sophomore students in health education, Helena Senior High:

Dave Willems	Sandy Dennis
Randy Haight	Curt Sanford
Jo Ann Gilreath	Micki Knutson
Darla Fryhover	Karen Graham
Dave Burt	Steve Morrison
Dolen O'Toole	Ken Swain
Eleanor Bushilla	Theresa Hopkins
Jeanne Ballard	Rick Campbell
Kelly Flaherty	Margrate McPherson
Julie Thomas	Leslie Cross
Tracy Pullin	Debbie Copeland

Other High School students: Glen Merenz, Fairfield; Melody Merenz, Fairfield; Connie Foster, Great Falls.

D. CONFERENCE PARTICIPANTS

GOVERNOR'S CONFERENCE ON HEALTH EDUCATION
April 15-17, 1974

ALTROGGE, Pat	325 Hannon Hall, MSU, Bozeman 59715
ALVES, Frances D.	Missoula City-Co. HD, Missoula 59801
BEHUNIN, Oral	3302 Sundance Drive, Bozeman 59715 (MSU)
BODEK, Diane	303 E. Cleveland, Bozeman 59715
BOUFFARD, Sister Anne L.	P.O. Box 750, Helena 59601 (Carroll)
BOWEN, Karen N.	Box 171, Belgrade 59714 (MSU)
BROWN, Margie	607 Eleventh Street N., Great Falls 59401
BYERLY, Frances S.	Box 900, Lewistown 59457
COGGESHALL, Jack	404 Fuller, Box 1677, Helena 59601 (MPS)
CRANE, Marilyn	312 S. Church, Bozeman 59715 (MSU)
DAYRIES, Dr. John L.	220 Cresline Dr., Missoula 59801 (U of M)
DRISCOLL, Sister Mary Rosaleen	24 S. Third St. Bozeman 59715 (MSU)
ELLIS, Vivian L.	1127 Third Ave. N., Great Falls 59401
ESTILL, Velma R.	Box 223, Hannon Hall, Bozeman 59715 (MSU)
EVANS, Dave	#3 Hidden Valley, Havre 59501 (Havre Jr. High)
FELDNER, Allen L.	Eastern Montana College, Billings 59101
FISHER, Roland K.	P.O. Box 543, Helena 59601 (Montana Hospital Assn.)
FLAMAND, Rose	Browning, 59417
FOSTER, Connie	2406 Sixth St. NW, Great Falls 59401 (Cyst. Fib.)
GEDROSE, Judy	1300 Sixth Ave. N, Great Falls, 59401
HILLARD, Phyllis	Montana State University, Bozeman 59715
HAINLINE, Edie	824 S. Eighth, Bozeman 59715
HALE, Conrad	Rm. 218, 201 S. Main, Helena 59601 (Fam. Plng.)
HENDERSON, Rose.	607 Eleventh Street N., Great Falls 59401
HOMER, Maxine	State Dept. Hlth and Inv. Sciences, Helena 59601
INEICHEN, George	Communications Officer, PHS, Region VIII, HEW, Denver
IVERSON, Glenn	Eastern Montana College, Billings 59101
JOHNSON, Gladys	817 W. Story, Bozeman 59715
JOHNSON, Paula	701 Nelson Story Tower, Bozeman 59715 (MSU)
KELLY, Tom	Carroll College, Helena 59601
KREBS, Maribelle	3640 York Road, Helena 59601 (Cystic Fibrosis)
KRESIC, Edna M., R.N.	801 S. Lake, Miles City 59301 (MSU student)
LANCE, Donna	105 Hannon, MSU, Bozeman 59715
LOUGHRIE, Robert	State Dept. Hlth.& Env. Sciences, Helena 59601
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E. EVALUATION SUMMARY

FIRST AND LAST DAY

Summary by Rating Scale and Comments.

Group I - First Day

HOW DID YOU FEEL ABOUT THIS SESSION? (Check number and comment)

	(1)	(1)	(3)	(2)	(2)	(2)	(1)	(5)
1	2	3	4	5	6	7	8	9	10
worthless				worthwhile					valuable

Students contribution very valuable in determining goals and objectives. (3 responses)
Parent/Student education extremely important.
Needed more real information rather than opinion. (2 responses)
Think we accomplished a lot today.
Discussion strayed too much.
Good Session.
Very good interaction for such a controversial subject.
Very good. Didn't realize some people were so ignorant about society's new morality.

Group II - First Day

HOW DID YOU FEEL ABOUT THIS SESSION? (Check number and comment)

		(3)	(1)		(3)	(3)	(2)		
1	2	3	4	5	6	7	8	9	10
worthless				worthwhile					valuable

Would appreciate the availability of more concrete help in form of more curriculum for health education in schools especially grades 3-7.
People presented their feelings but I couldn't see anything done worthwhile.
I'm interested in getting students involved with health programs in our district and today was a good help.
This has been an awareness education program for me--it opened my eyes to problems. (4 responses)
Want information on how the Curriculum Guide will be introduced to communities--how can we help--will we receive directions.
Accomplished more in this session than yesterday.

Group III - First Day

HOW DID YOU FEEL ABOUT THIS SESSION? (Check number and comment)

			(2)	(2)	(2)	(8)			
1	2	3	4	5	6	7	8	9	10
worthless				worthwhile					valuable

Unfortunate that we don't have more top people here that could take effective action about problems we discuss.
Good start--good participation. Expect to see good results of this group by the end of the program. (3 responses)
Don't seem to be progressing toward any concerted solution of problems.
Dynamic leader--much group participation. Direction for remaining sessions established.
Found group interested and enthusiastic.

SUMMARY EVALUATIONS

I liked the suggestion that was made about taking action.
We need to go where the people are. I like the idea of blood pressure being taken while in line for vehicle licenses.
A concerned generation is coming up, although it may be too late to help parents.
Awareness is important--actual behavior and attitude change is the ultimate goal.

Group IV - First Day

HOW DID YOU FEEL ABOUT THIS SESSION? (Check number and comment)

(3) (2)

1.....2.....3.....4.....5.....6.....7.....8.....9.....10
worthless worthwhile valuable

It was valuable.
We got some ideas tossed out that need more solidification.
Very well spent--accomplished a considerable amount.
Good job.

Group I - Last Day

HOW DID YOU FEEL ABOUT THIS SESSION? (Check number and comment)

(2) (3) (7) (7) (2) (1) (7)

1.....2.....3.....4.....5.....6.....7.....8.....9.....10
worthless worthwhile valuable

Good in general. (6 responses)
H.S. Girls should have been questioned more about their feelings concerning Health Ed.
Could have accomplished more.
Don't think we stuck to the topics involved.
Not enough definitive ideas for ACTION.
Worthwhile if action is taken and suggestions that were made are carried through.
Very interesting to know how these meetings are conducted.
Heard a lot of feelings to indicate we have potential--if we can put it into action.
Programming is one thing, implementing another.
Continue trying to get action.
Good Leader to bring out thoughts of many.
This was very good. Group really tried to do something that is really needed in Montana
Very interesting and certainly worthwhile but too bad that more teachers, health educators do not have the courage of their convictions.
Why aren't nurses considered in teaching health education in schools, teachers do not have the knowledge of health that nurses do--health is forever!
Improvement over yesterday.

Group II - Last Day

HOW DID YOU FEEL ABOUT THIS SESSION? (Check number and comment)

(1) (1) (1) (3) (4)

1.....2.....3.....4.....5.....6.....7.....8.....9.....10
worthless worthwhile valuable

We got to talk about what we think is right or wrong. Maybe get a committee to go to school and go through the same thing we did today.
We are talking about what I came to discuss.

SUMMARY EVALUATIONS

I would like to know more about what students could possibly do to get more health education in our schools. Maybe a project a student council could help with.
Problems and possible solutions certainly made awareness of the need for more health education.

Group III - Last Day

HOW DID YOU FEEL ABOUT THIS SESSION? (Check number and comment)

(1) (5) (5)

1.....2.....3.....4.....5.....6.....7.....8.....9.....10

worthless worthwhile valuable

One of the best organized and developed sessions I have ever attended. (2 responses)
Appeared that we accomplished an objective.
Group did document recommendations and fulfilled its charge (2 responses).
Great group to work with--feel that some concrete recommendations were developed out of utter chaos.
Thank God we finished!
A lot was accomplished.
I've become increasingly aware of lack of information between providers of health services. I intend to attempt to remedy at least my aspect of the problem by increased contact with health providers.
Feel it produced solid recommendations.

Group IV - Last Day

HOW DID YOU FEEL ABOUT THIS SESSION. (Check number and comment)

(1) (2) (4)

1.....2.....3.....4.....5.....6.....7.....8.....9.....10

worthless worthwhile valuable

Good job. (2 responses)
Worthwhile discussion and efforts to delineate solutions to some problems.